Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS298AGZ	A. BUILDING _____ B. WING _____	06/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ASSTD LV AT MIRA LOMA	2520 WIGWAM PARKWAY HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/19/09 and completed on 6/23/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 94 Residential Facility for Group beds for elderly and disabled persons and/or 30 Residential Facility beds which provide care for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 96. Three resident files were reviewed. Complaint #NV00022237 was substantiated. See Tag Y850 The following deficiencies were identified:	Y 000		
Y 850 SS=D	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the	Y 850		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 850	Continued From page 1 resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a resident who suffered a head injury after a fall (Resident #1). Severity: 2 Scope: 1	Y 850		